Application Template for
Health Insurance Flexibility and Accountability (HIFA)
Section 1115
Demonstration Proposal

The State of California Health and Human Services Agency proposes a section 1115 demonstration entitled the California Parental Coverage Expansion, which will increase the number of individuals with heath insurance coverage.

I. GENERAL DESCRIPTION OF PROGRAM

The Parental Coverage Expansion Waiver will provide health insurance coverage to an additional 275,000 residents of the State of California with incomes at or below 200 percent of the Federal poverty level. The increased coverage will be funded by the State's Tobacco Settlement Fund.

II. DEFINITIONS

Income: *Income in this waiver application means net income, adjusted in accordance with the state's existing deductions in the Healthy Families and Medi-Cal programs.*

Mandatory Populations: Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and pregnant women up to 133 percent of poverty.

Optional Population: Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstration, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.

Expansion Populations: Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

Private health insurance coverage: This term refers to both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act.

III. HIFA DEMONSTRATION STANDARD FEATURES

Please place a check mark beside each feature to acknowledge agreement with the standard features.

_X_ The HIFA demonstration will be subject to Special Terms and Conditions (STCs). The core set of STCs is included in the application package. Depending upon the design of its demonstration, additional STCs may apply.

_X_ Federal financial participation (FFP) will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, maintenance of effort requirement will apply.

_X_ Any eligibility expansion will be statewide, even if other features of the demonstration are being phased-in.

_X_ HIFA demonstrations will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to SCHIP eligibles.

> *The State will draw Title XXI matching funds for both the Medi-Cal-to-Health Families bridge program and the Health Families-to-Medi-Cal bridge program, even though individuals in the Healthy Families-to-Medi-Cal bridge program are Medicaid-eligible.*

_X_ Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability or premium and cost sharing contributions made by or on behalf of program participants.

_X_ The State has utilized a public process to allow beneficiaries and other interested cardholders to comment on its proposed HIFA demonstrations.

> *The State conducted an extensive public comment process regarding the proposed waiver early in 2001.*

IV. STATE SPECIFIC EVENTS

- **Upper income limit**

The upper income limit for the eligibility expansion under the demonstration is 200 percent of the FPL.

- **Eligibility**

Please indicate with check marks with populations you are proposing to include in your HIFA demonstration.

__X__ *Title XXI parents (Separate SCHIP Program)*

C. Enrollment/Expenditure Cap

___ No

_X_ Yes

(If Yes) Number of participants __n/a__
or dollar limit of demonstration __n/a__

The program is "capped" in the sense that it is limited by the State's SCHIP allotment and annual State legislative appropriations. If there were not sufficient funds, the State would maintain a waiting list for the expansion population (parents).

D. Phase-In

Please indicate below whether the demonstration will be implemented at once or phased-in.

__X__ *Coverage under the HIFA demonstration will not be phased in.*

E. Benefit Package

Please use check marks to indicate which benefit packages you are proposing to provide to the various populations included in your HIFA demonstration.

3. SCHIP populations, if they are to be included in the HIFA demonstration

States with approved SCHIP plans may provide the benefit package specified in Medicaid State plan, or may choose another option specified in Title XXI. (If the State is proposing to change its existing SCHIP State Plan as part of implementing a HIFA demonstration, a corresponding plan amendment must be submitted.) SCHIP coverage will consist of:

____ The same coverage provided under the State's approved Medicaid State plan.
____ The benefit package for the health insurance plan this is offered by the HMO and has the largest commercial, non-Medicaid enrollment in the State.
____ The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP))
__X__ A health benefits coverage plan that is offered and generally available to State employees
____ A benefit package that is actuarially equivalent to one of those listed above
____ Secretary approved coverage. (The proposed benefit package is described in Attachment D.)

F. Coverage Vehicle

Please check the coverage vehicle(s) for all applicable eligibility categories in the chart below (check multiple boxes if more than one coverage vehicle will be used within a category):

Eligibility Category	Fee-For-Service	Medicaid or SCHIP Managed Care	Private health Insurance Coverage	Group Health plan coverage	Other (specify)
Mandatory					
Optional-Existing					
Optional-Expansion					
Title XXI - Medicaid Expansion					
Title XXI-Separate SCHIP		X	X		
Existing section 1115 expansion					
New HIFA Expansion					

A detailed description of the State's private health insurance coverage options is provided in Attachment D.

G. Private health insurance coverage options

Coordination with private health insurance coverage is an important feature of a HIFA demonstration. One way to achieve this goal is by providing premium assistance or "buying into" employer-sponsored insurance policies. Description of additional activities may be provided in Attachment D to the State's applicant for a HIFA demonstration. If the State is employing premium assistance, please use the section below to provide details.

As a component of its waiver request, the State will conduct a feasibility study about coordinating the Healthy Families Program with private, employer-based health insurance coverage. Please see Attachment D for further description.

H. Cost Sharing

Please check the cost sharing rules for all applicable eligibility categories in the chart below:

Eligibility Category	Nominal Amounts Per Regulations	Up to 5 Percent of Family Income	State Defined
Mandatory			
Optional - Existing (Children)			
Optional - Existing (Adults)			
Optional - Expansion (Children)			
Optional - Expansion (Adults)			
Title XXI - Medicaid Expansion			
Title XXI - Separate SCHIP			Parents
Existing section 1115 Expansion			
New HIFA Expansion			

Cost-sharing for children
Only those cost-sharing amounts that can be attributed directly to the child (i.e. co-payments for the child's physician visits or prescription drugs) must be counted against the cap of up to five percent of family income. Cost-sharing amounts that are assessed to a family group that includes adults, such as family premiums, do not need to be counted as "child cost-sharing" for the purposes of the up to five percent cost-sharing limit. A premium covering only the children in a family must be counted against the cap.

Below, please provide a brief description of the methodology that will be used to monitor child-only cost-sharing expenses when the child is covered as part of the entire family and how those expenses will be limited to up to five percent of the family's income.

This waiver proposal involves no potential increase in child-only cost-sharing expenses. The State is not proposing any changes in cost sharing for children. Please see Attachment E for further discussion of cost sharing.

Any State defined cost-sharing must be described in Attachment E. In addition, if cost-sharing limits will differ for participants in a premium assistance program or other private health insurance coverage option, the limits must be specified in detail in Attachment E to you proposal.

V. Accountability and Monitoring

Please provide information on the following areas:

- **Insurance Coverage**

The rate of uninsurance in your State as of_____ for individuals below 200 percent of poverty and any other groups that will be covered under the demonstration project:

The followinginformation is from "The State of Health Insurance in California: Recent Trends, Future Prospects" by the UCLA Center for Health Policy Research , an analysis of 1999 CPS data

Adults

	Below Poverty	*100 to 250% FPL*
Uninsured	*51%*	*39%*
Job-Based Insurance	*18%*	*43%*
Privately Purchased	*3%*	*5%*
Medicaid	*26%*	*11%*
Other Public	*2%*	*2%*

Children

	Below Poverty	*100 to 250% FPL*
Uninsured	*27%*	*24%*
Job-Based Insurance	*17%*	*48%*
Privately Purchased	*1%*	*4%*
Medicaid	*53%*	*24%*

Indicate the data source used to collect the insurance information presented above (the State may use different data sources for different categories of coverage, as appropriate):

__X__ The Current Population Survey

Adjustments were made to the Current Population Survey or another national survey.

____ Yes __X__ No (*The information was based on the California subset, so no adjustments were needed to make it state-specific.)*

A State survey was used.

____ Yes __X__ No

Given the size of California's population we are able to use data collected in the Current Population Survey (CPS) to provide reasonably accurate estimates of the kinds of health

coverage Californians have. In recent years the California CPS data have been analyzed in detail by researchers at UCLA.

UCLA has the capacity to provide additional statistics showing coverage sources where the population is divided using different income limits. Because our existing S-CHIP program provides children's coverage up to 250 percent of poverty, we have been tracking children's coverage below that threshold. This proposal for parents would extent coverage up to 200 percent of poverty. We will ask UCLA to provide the above break-out dividing the population between those above and below 200 percent of the federal poverty level in order to provide a clearer picture of the distribution of coverage among the adult categories of interest under this waiver.

UCLA has published analyses of health coverage in California since 1996 and has continued support for the coming two years. Because of this annual effort, California has some of the best state-level information regarding the sources of health coverage for the population available anywhere in the nation. California will rely on this experience to continue the data series to monitor the rate of uninsured in California. UCLA's most recent analysis can be viewed at:
http://www.healthpolicy.ucla.edu/publications/TheStateofHealthInsinCalifFullReport2001.pdf

2. State Coverage Goals and State Progress Reports

The goal of the HIFA demonstration is to reduce the uninsured rate. For example, if a State was providing Medicaid coverage to families, a coverage goal could be that the State expects the uninsured rate for families to decrease by 5 percent. Please specify the State's goal for reducing the uninsured rate:

If this waiver is approved, the State will be monitoring and evaluating the progress and success of the demonstration project. The following is a brief description of the demonstration proposal's hypothesis and research design:

Demonstration Hypothesis

The primary hypothesis being tested in this demonstration waiver is that a greater percentage of eligible children will be enrolled in California's Healthy Families Program if coverage is offered to the parental decision-makers in the household.

A secondary hypothesis is that the continuity of children's coverage will be increased in California's Healthy Families Program, if coverage is offered to the parental decision-makers in the household.

Demonstration Evaluation

The demonstration objectives for California's waiver request are to test and validate or disprove the hypotheses described above.

- *The state is testing the hypothesis that the enrollment of eligible children in the HFP (and in the 100-133 percent FPL and Share of Cost Medi-Cal income range) will increase more than the number otherwise projected without the adoption of family coverage. The*

provision of coverage through a family-based approach is estimated to improve the enrollment rates of HFP eligible children from the existing "child-only" projections of 80 percent of children (using 1999 CPS estimates on eligible children as analyzed by UCLA), to 89 percent of eligible children. This is an increase of approximately 11 percent. The target numbers will be updated, as more recent data becomes available.

- *The state is testing the hypothesis that the length of time that children covered under family coverage are enrolled in the HFP will be longer than the length of enrollment of children not covered under family coverage. Specifically, the State is testing whether children enrolled in the HFP with their parents will remain enrolled significantly longer than children enrolled in the HFP without their parents will.*

RESEARCH DESIGN

Increased enrollment of children

Using application and enrollment data the State will compare the number of children enrolled in the HFP and the rate of enrollment in the HFP prior to the expansion of the program to include parents, with the number and rate of enrollment after the parental expansion.

The State will evaluate whether any observed change in enrollment rate is impacted by whether the child and parent are enrolled in the same program (MC versus HFP) and/or health plan.

Improved retention rate of children enrolled

Using enrollment and disenrollment data, the State will compare the year to year retention rates of children prior to and after the parental expansion. The State will compare the average length of enrollment of children prior to and after the parental expansion.

In an effort to better isolate the effect of the parental expansion on the retention of children, the State will also look at the length of enrollment of children who are enrolled with their parents as compared to the length of enrollment of children who are not enrolled with their parents.

Contrasting both length of enrollment and disenrollment rates among all children enrolled prior to and after the parental expansion, and length of enrollment and disenrollment rates of children enrolled with or without their parents after the parental expansion will help control for the effects of any other actions taken to reduce disenrollments overall.

The State will evaluate whether any observed change in retention rate is impacted by whether the child and parent are enrolled in the same program (MC versus HFP) and/or health plan.

__X__ Annual progress reports will be submitted to CMS six months after the end of each demonstration year which provide the information described in this plan for monitoring the uninsured rate and trends in sources of insurance coverage.

VI. PROGRAM COSTS

A requirement of HIFA demonstration is that they not result in an increase in federal costs compared to costs in the absence of the demonstration. Please submit expenditure data as Attachment G to your proposal. For your convenience, a sample worksheet for submission of base year data is included as part of the application packet.

California is seeking to claim against the state's SCHIP allotment for this waiver request. Budget neutrality for this waiver is predicated on the statutory limitation of state allotments under S-CHIP. The state's S-CHIP allotment will first be used to cover targeted low-income children, with the remainder used to cover the waiver expansion. Based on projections of California's allotments, the funding would be sufficient to fund both eligible children and the parent coverage expansion.

The State will enter into the required allotment neutrality agreement with CMS. The State understands that allotment neutrality does not include funds redistributed from other states as provided under current law, if such funds are not available to the State on an ongoing basis, and that the demonstration project will not result in changes to the rate for federal matching payments for program expenditures.

VII. WAIVERS AND EXPENDITURE AUTHORITY REQUESTED

B. Expenditure Authority

Expenditure authority is requested under Section 1115(a)(2) of the Social Security Act to allow the following expenditures (which are not otherwise included as expenditures under Section 1903 or Section 2105) to be regarded as expenditures under the State's Title XIX or Title XXI plan.

Note: Checking the appropriate box(es) will allow the State to claim Federal Financial Participation for expenditures that otherwise would not be eligible for Federal match.

Title XXI:

___X__ Expenditures to provide services to populations not otherwise eligible under a State child health plan.

If additional waivers or expenditure authority are desired, please include a detailed request and justification as Attachment H to the proposal.

Attachment H describes additional waivers requested.

VIII. ATTACHMENTS

Place check marks beside the attachments you are including with your application.

___X__ Attachment A: Discussion of how the State will ensure that covering individuals above 200 percent of poverty under the waiver will not induce individuals with private health insurance coverage to drop their current coverage. *The demonstration project would not cover individuals above 200 percent of poverty but we have included information about our efforts concerning substitution of coverage.*

___X__ Attachment B: Detailed description of expansion populations included in the demonstration.

___X__ Attachment C: Benefit package description.

___X__ Attachment D: Detailed description of private health insurance coverage options, including premium assistance if applicable.

___X__ Attachment E: Detailed discussion of cost sharing limits.

___X__ Attachment F: Additional detail regarding measuring progress toward reducing the rate of uninsurance.

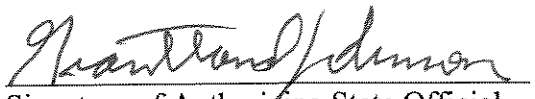
__X___ Attachment G: Budget worksheets.

__X___ Attachment H: Additional waivers or expenditure authority request and justification.

IX. SIGNATURE

January 10, 2002 — Date

Grantland Johnson, Secretary of Health and Human Services — Name of Authorizing State Official (Typed)



Signature of Authorizing State Official

Attachment A: Substitution of Coverage

As with the current HFP, parents with employer-sponsored coverage in the past three months will not be eligible for HFP Coverage (the current exceptions to this rule, such as loss of job, will continue to apply).

Other strategies used by the State to deter substitution of employer sponsored coverage for publicly funded coverage are:

- The imposition of cost sharing on all families.
- The inclusion of a question regarding employer coverage on the program application.
- State law that prohibits insurance agents and employers from designing benefit plans or altering employer contributions to encourage enrollment in the Healthy Families Program.
- Inclusion of a module on prohibitions against substitution in all training provided to application assistants.

Attachment B: Waiver Populations

The waiver population consists of two groups:

1. Demonstration Population 1: Uninsured custodial parents, caretaker relatives and legal guardians of children eligible under the title XIX state plan or the title XXI state plan, when the parents and caretakers have family incomes at or below 200 percent of the FPL and are not eligible for Medi-Cal. The state will adopt the following definition of parent in both the Healthy Families Program and Medi-Cal: a natural or adoptive parent, stepparent, legal guardian, or caretaker relative with whom the child resides. All parents determined eligible under this waiver will be linked. through the definition of parent, to an eligible child. Financial responsibility and treatment of income for children will continue to be in accordance with existing Medi-Cal and Healthy Families regulations (e.g. Sneede lawsuit). California does not intend to apply additional eligibility criteria other than those that would otherwise apply under Medi-Cal or SCHIP.

2. Demonstration Population 2: Individuals whose one-year continuous eligibility for Healthy Families ends, when the individual has been determined potentially Medi-Cal eligible but a final Medi-Cal eligibility determination has not been made, or when the individual has been determined Medi-Cal eligible but the individual has not yet been enrolled in a Medi-Cal health plan.

Parents will be eligible for HFP to the extent that financial resources are available to fully cover eligible children first. California's Healthy Families Demonstration project will extend coverage through the Healthy Families Program (HFP) to parents of eligible children in families with incomes between 100 and 200 percent of the federal poverty level and parents with incomes below 100 percent of the federal poverty level who do not qualify for Medi-Cal (e.g. excess assets). Parents will qualify for Healthy Families without regard to family assets.

Those families and children currently eligible for or enrolled in "share of cost" Medi-Cal with incomes above 100 percent of FPL but below the upper income limits, can enroll in Healthy Families (which is current policy for children).

Since the HFP's inception, the State has provided a "one-month bridge" for those children living in families with incomes that no longer qualify for no-cost Medicaid. The one-month bridge continues the child's coverage for an additional month while the family enrolls the child in the HFP. As part of this waiver request the State is proposing to extend the Medi-Cal to HFP bridge to parents enrolled in no-cost Medi-Cal that are no longer eligible due to an increase in family income. Each person enrolled in a Medi-Cal health plan will continue his or her enrollment in the same health plan during the transition period or until a new choice form is received by the respective program's enrollment contractor.

To further the seamless process, the State proposes to provide children and parents with two months of continued eligibility in the Healthy Families Program (via a "HFP to Medi-Cal" bridge) when HFP determines at annual eligibility review that the household income qualifies the child or parent for no

cost Medi-Cal eligibility. These additional days provide continued access to care while the County Welfare Department completes the final eligibility determination.

To simplify the programs' rules, we are proposing to standardize both the Medi-Cal to HFP and the HFP to Medi-Cal bridge coverage period at two months. In accordance with previous discussions between the State and CMS, costs associated with both bridge programs will be billed to Title XXI.

The State will extend continuous eligibility with annual eligibility reviews to parents enrolled in the HFP similar to the provisions governing children in HFP. (The State will continue discussions with CMS on ways to extend this provision to parents enrolled through the Medi-Cal program.)

Attachment C: Benefit Package Description

The benefit package that will be offered to parents is the same benefits package provided to children. Parents will be offered health, dental and vision coverage. The benefits offered to parents will be based on the state employees' benefits package. California is proposing to require copayments as follows: $5 copayments for health and vision benefits and state employee copayments for dental services.

The benefit package for adults is as follows:

Health		
Physician Services	Office, home visits Allergy testing and treatment	$5 per visit
Preventive Care	Periodic health examinations Variety of voluntary family planning services Vision and hearing testing Immunizations Venereal disease tests Annual Pap smear exams Health education services	$5 per visit
Prescription Drugs	30-34 day supply of brand name or generic drugs, including prescriptions for one cycle of tobacco cessation drugs 90-100 day supply of maintenance drugs While in the hospital FDA approved contraceptive drugs and devices	$5 per prescription
Hospital services	Inpatient care	No charge
Emergency Health Care services	24 hour emergency care	$5, waived if admitted as inpatient.
Prenatal Care	Prenatal and postnatal care, inpatient and newborn nursery care	No charge
Medical Transportation	Emergency medical transportation	No charge
Diagnostic X-ray and Lab	Inpatient and outpatient	No charge
DME	Medical equipment appropriate for use in the home	No charge
Mental Health	Diagnosis and treatment of serious mental illness. Benefits include outpatient, inpatient, and partial hospitalization services and prescription drugs.	No charge for inpatient, $5 outpatient
Alcohol and Drug Abuse	• Inpatient (for detoxification) • Outpatient: 20 visits per year	• No charge • $5/visit
PT/OT/Speech Therapy	Short-term therapy for a period not exceeding 60 consecutive calendar days per condition following the date of the first therapy session. Additional therapy beyond the 60 days is provided if medically necessary.	No charge for inpatient $5 for outpatient
Home Health Care	Must be prescribed or directed by the attending physician or other appropriate authority designated by the plan	$5/ visit if performed in the home.
Skilled Nursing Care	Inpatient: 100 days per benefit year	No charge
	Optional Health Benefits	
Acupuncture	20 visits per benefit year	$5 per visit
Chiropractic	20 visits per benefit year	$5 per visit

Biofeedback	8 visits per benefit year	$5 per visit

Vision Benefits		
Eye Examinations	Once every 12 months	$5 per visit
Prescription Glasses	Once every 12 months	$5 per glasses, frames or lenses

Dental Benefits		
Diagnostic and Preventive Care	Cleanings and X-rays	No copay
Restorative Care	Fillings	No copay, except for microfilled resin restorations ($40 per surface)
Oral Surgery	Extractions, removal of impacted teeth	No copay, except for bony impaction ($15) and root recovery ($5 per root)
Endontics	Treatment of tooth pulp	No copay, except root canal $20 per canal, apicoectomy ($60 per canal)
Periodontics	Treatment of gums and bones that support the teeth	No copay, except osseous or muco-gongival surgery ($150 per quadrant); gingivectomy ($5 per tooth)
Crowns and Bridges	Only provided to treat cavities that cannot be restored with fillings	No copay, except specified crowns and pontics ($40-$50)
Removable Prosthetics	Dentures	Complete upper $65; Complete lower $65; Partial acrylic $5; partial alloy $65

Differences between the benefit packages for parents and children in the Healthy Families Program are primarily in the area of copayments for dental services. The proposed vision benefits for parents mirror the services currently provided to children. The proposed health benefits for parents differ from the current benefits offered to children in a few areas. These areas are described below.

Benefit Category	HFP Children's Benefit	HFP Parent's Benefit
Eye Refractions offered through health plans*	Covered	Optional
Hearing Aids	No benefit dollar limit for the hearing instrument and ancillary equipment.	$1,000 benefit limit for the hearing instrument and ancillary equipment.
Tobacco Cessation Classes	No charge	Plans may charge subscribers for part or all of the cost for classes or may require up-front payment, which is reimbursed upon successful completion of the course.
County Mental Health Services	Provided for children who are seriously emotionally disturbed	All mental health services provided through health plans
California Children's Services Program	Provided to children with medically handicapping conditions.	No applicable program exists for adults. All specialty care is provided through health plans.

Eye refractions are covered for parents through vision plans.

The proposed dental benefits for parents differ from the current benefits offered to children in a few areas. These areas are described below.

Benefit Category	HFP Children's Benefit	HFP Parent's Benefit
Full-mouth x-rays	Covered once every 24 consecutive months	Covered once in a three-year period.
Panoramic films	Covered once every 24 consecutive months	Covered once in a three-year period.
Prophylaxis services	Limited to two in a 12-month period.	Covered twice in a 12-month period. A third cleaning may be covered for high-risk individuals.
Replacement of crowns	Limited to once every 3 years.	Limited to once every 5 years.
Partial dentures	Replaced every 3 years with some exceptions	Replaced every 5 years with some exceptions.
Orthodontia Services	Limited orthodontia services are covered through the California Children's Services program.	Not covered

Attachment D: Private Health Insurance Options

I. The current and proposed delivery system: HFP Purchasing Pool

Basic Structure

The parental coverage expansion waiver will use the same health plans and administrative structures as the Healthy Families Program for children currently uses. The HFP is modeled on the design features of employer-based health coverage. Children enrolled in the HFP are eligible for a comprehensive package of health, dental and vision benefits. Benefits provided to children in the HFP are "benchmarked" on benefits provided to state employees. HFP parents would receive the current benchmark standard for HFP, namely the state employees' benefit package, which includes dental and vision. Currently in HFP, certain children-specific benefits such as California Children's Services (CCS) and Severe Emotional Disorders (SED) benefits for children are covered via "carve-out specialty networks". CCS provides treatment for children's specialized health conditions. Similar services for adults will be provided directly by health plans' provider networks, except for parents who themselves qualify for CCS services. Adult mental health services will also be provided directly by HFP health plans' provider networks.

Twenty-six health plans, five dental plans and one vision plan participate in the HFP. Parents select their children's plans from those available in a geographic area in which the child lives. An annual open enrollment period is held each spring during which parents may choose to move their child to a new health or dental plan.

For HFP, cost sharing is required for participation. The cost sharing proposed for parents is described in attachment E.

A 90-day period without insurance is required of children who were previously enrolled in employer-sponsored health coverage, with exceptions granted in limited circumstances, such as loss of a job.

The delivery system for parents will be the same as the system used for children. All health, dental and vision plans currently participating in the Healthy Families Program will be offered to parents. The health plans offered to children are primarily HMOs (health maintenance organization) with two EPOs (exclusive provider organization) providing coverage in the rural areas of the state. The dental plans offered include two DMO (dental maintenance organization), one EPO dental plan and one fee-for-service plan. The vision plan provides a broad network of providers throughout the state.

Access to Care Through Cooperation With Plans' Regulator

The California Department of Managed Health Care (DMHC) enforces the standards for access to services and the capacity of health plan networks. Before the HFP opened to children on July 1, 1998, the Managed Risk Medical Insurance Board worked closely with the Department of Corporations (the regulatory entity which preceded the current DMHC, to address concerns regarding provider access. At that time, the DOC required plans to demonstrate 1) their ability to accept new enrollees from the HFP and 2) adequacy of their systems to monitor access and respond to new demands for providers.

All of the plans participating in the HFP are currently serving adults. These delivery systems contain the appropriate personnel to deliver care to parents. In addition, based on the state's previous experience with the HFP and other insurance programs, the state anticipates that enrollment of parents will increase over time, giving participating plans an opportunity to enhance their capacity in anticipation of the increased need.

The MRMIB is working with the DMHC to assure that all plans currently serving children are prepared to enroll parents when the waiver is implemented. DMHC is aware that the HFP will be expanded to cover parents (subject to the approval of the 1115 waiver) and has agreed to provide the necessary support to ensure that participating plans are appropriately licensed and able to service the targeted population.

Assuring Delivery of Quality Care

The mechanisms that are currently used to assure the delivery of quality care for children will be used for parents. First and foremost, all plans participating in the HFP must be in good standing with the regulatory entity for managed health care plans, and therefore, compliant with the state's regulatory standards for managed care plans. Many of these standards address access and quality of care. Health plans must comply with these regulatory standards to obtain and retain their license to provide care in California. The regulatory entity, the Department of Managed Health Care, periodically reviews health plans for compliance with these standards. Many of the health plans participating in the HFP were recently under review by the Department of Managed Health Care.

Second, MRMIB collects information from several key sources to monitor quality of care. These sources provide information regarding the care that is delivered to subscribers:

Fact Sheets
The Fact Sheets request information regarding the organization of the health plan and the provision of services. The Fact Sheets include several questions regarding the provision of specialty and mental health services. These questions will provide the basis for reviewing the quality of services provided to subscribers. Fact Sheets are submitted by the plans annually.

Cultural and Linguistics Services and Group Needs Assessment Reports
These reports allow the state to monitor how special needs of HFP subscribers related to language access, and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans will provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How plans assign subscribers to culturally and linguistically appropriate providers
- How plans provide interpreter services to subscribers
- How plans provide culturally and linguistically appropriate marketing materials
- A list of written materials plans make available in languages other than English

The Group Needs Assessment Report will identify the unique perspectives of subscriber based on their cultural beliefs. Participating plans are required to conduct an assessment of their subscribers to determine:

- Health-related behaviors and practices
- Risk for disease, health problems and conditions
- Knowledge, attitudes, beliefs and practices related to access and use of preventive care
- Knowledge, attitudes, beliefs and practices related to health risk
- Perceived health, health care and health education needs and expectations
- Cultural beliefs and practices to alternative medicine

The assessment must also include an evaluation of community resources for providing health education and cultural and linguistic services and the adequacy of the network. Based on the results of the assessment, each plan is required to develop a program to address the needs identified in the group needs assessment. The group needs assessment reports, like the Fact Sheets, provide the basis for reviewing the quality of services provided to subscribers. Participating plans will submit their first group needs assessment reports in June 2001.

Annual Quality of Care Reports
HEDIS is one of three primary tools used to collect quality information from health plans. The state has recently collected quality data related to mental health care through the HEDIS mental health measure. This measure has been a standard reporting requirement and is anticipated to be a reporting requirement in future health plan contracts. With the inclusion of adults in the HFP, HEDIS measures that are relevant to adult health will be included as new contract requirements.

Member Surveys
Member surveys are also used to collect quality information from health plans. MRMIB uses two member surveys to monitor quality and service. During open enrollment, all subscribers are given a plan disenrollment survey to determine why they switched plans. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. This survey will be modified to capture information regarding quality of care received by parents.

MRMIB also conducts a consumer satisfaction survey. The first survey for the HFP was conducted in the fall of 2000. The survey was based on the Consumer Assessment of Health Plans Survey (CAHPS® 2.0) and was conducted in five languages (English, Spanish, Chinese, Korean, Vietnamese). Responses from the survey will provide information on access to care (including specialty referrals), quality of provider communication with subscribers, and ratings of providers, health plans and overall health care. With the addition of parents to the HFP, the adult version of CAHPS will be implemented

Subscriber Complaints
MRMIB receives direct inquiries and complaints from HFP applicants. All HFP inquires and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of complaint. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints, and 4) monitor the plan's ability to meet the linguistic needs of subscribers

II. HFP Premium Assistance Feasibility Study

California will include as a component of its SCHIP 1115 Waiver Request a feasibility study of coordinating the Healthy Families Program (HFP) with private health insurance coverage. The goal of a premium assistance program is the same as our base program: to increase the enrollment of eligible children in comprehensive health coverage.

California State law contains the basic authority for a premium assistance-based approach, however this strategy has not been implemented due to "cost effectiveness" language in the state law that makes the concept unworkable.

The Managed Risk Medical Insurance Board (MRMIB) of the Health and Human Services Agency will take lead responsibility for preparation of the feasibility study. While the study is not contingent on outside funding, the State will seek philanthropic support to assist in study design and execution. At least two California based philanthropies have previously funded work related to premium assistance and may view the State's proposal for assistance favorably.

The Health and Human Services Agency will work with stakeholders from the advocacy, health plan, provider, and employer communities to develop the specifics of the study design. Public review of the study design and preliminary findings will be provided via the public MRMIB and HFP Advisory Panel meetings. California's statute permits the State to work with purchasing cooperatives to implement the premium assistance program. Several cooperatives operate within California – these entities will be included in the early planning efforts, as will health plans serving large employer groups.

Feasibility Study Goal

The goal of the State's feasibility study will be to describe a model for premium assistance that is tailored to the characteristics of California's employer and insurer marketplace and to specify the implementation strategy. Key issues that the feasibility study will assess include:

1. Eligibility-Related Issues

   The feasibility study will develop options to and make a recommendation regarding how best to:

   - Obtain and verify information on the availability of employer-based coverage. Such information includes the specific services covered, the amount of any deductibles and copayments, and the amount of the employer's contribution toward dependent coverage; and,
   - Verify that the family has used the funds to purchase the employer's plan

The feasibility study will also evaluate whether there is a need for changes to state insurance laws regarding "qualifying events" and open enrollment periods. A large set of eligibility issues relate to

what happens when the wage earner in a family receiving premium assistance changes jobs and loses access to the employer's plan – the goal is to provide seamless coverage to the family with no break in coverage. Whether families should have a choice of premium assistance or the core HFP program will also be addressed in the feasibility study.

2. Benefit-Package Issues

Federal SCHIP regulations provide benefit package flexibility beyond that utilized in the HFP. The feasibility study will address whether additional eligible children would be covered if an alternative benefit package were adopted. This assessment will require the gathering of standardized information on the benefits currently offered to employees and dependents by California employers and the employer contributions to the coverage. The goal of this aspect of the analysis will be to identify those plan offerings in the small employer market and employers' plans in the large group market that meet the basic coverage parameters of the HFP.

As a starting point, the State has assumed that premium assistance will be considered only for the health benefits portion of the HFP. Children whose families are receiving premium assistance will be enrolled in the base HFP for dental and vision coverage. The appropriateness of this assumption will be explored in the feasibility study.

3. Flow of Fund Issues

The State's preliminary review indicates that the key to development of a successful premium assistance program is to design an administrative infrastructure that is simple for families, employers and health plans. This means the State (or state vendors) will assume the bulk of the administrative burden. This study could examine specific assistance that could be provided to small employers, which are less likely to have their own human resources departments to manage benefits and premium assistance. Few operational examples exist of successful premium assistance programs that accomplish this goal. The State's feasibility study will address policy and operational issues regarding when it is cost effective to provide premium assistance, how and to which entities the premium assistance funds will flow (whether to families, plans, or employers). Policy concerns regarding program fiscal integrity and administrative burden will be evaluated for each of the options reviewed.

Timing Of Study

It is anticipated that the study will take 18 months to design, conduct and finalize. Work on the study will begin when the parents coverage program described in this waiver is operational. This will assure that the operational issues inherent in the expansion of HFP from a children's program to a family program are adequately addressed in the State's premium assistance feasibility study and planning process. The study will include consultation with stakeholder groups through the public forums available to MRMIB to allow for public review and comment.

Work Product

At the completion of the study, California will submit a report to CMS describing the study design, the findings, and next steps for implementation of a premium assistance program. This will include:

- The design of the premium assistance program to be implemented.
- An implementation timetable.
- A request for additional waivers that may be required to implement the proposal.
- Identification of the target groups, if any, that may be chosen for participation.
- A description of any changes to state law that would be required to implement the program.
- Estimated budget.

If the study's findings indicate that a premium assistance program is not feasible for California, detailed descriptions of the reason for this conclusion will be provided.

Attachment E: Cost Sharing Limits

Families in the HFP will pay monthly premiums based on income category, the number of people covered, and the composition of the family. Premiums for HFP children will remain the same as they have been since the inception of the HFP in 1998. HFP parents will pay premiums as follows:

- For families up to 150 percent of FPL premiums will be $10 per parent per month;
- Above 150 percent FPL each parent will pay $20 per month.

Premium discounts will be consistent with those currently available to HFP children.

- Families that enroll in the Community Provider Plan will receive a $3 per member per month discount for each family member for whom a premium is paid.
- Cost sharing will be waived for American Indian and Alaska Natives.
- Families that pay three months' premium in advance will receive the fourth month free.

In addition the following program enhancements are being implemented:

- Families that sign up for electronic fund transfer will be offered a premium discount commensurate with the "pay three in advance" discount.
- The existing practice of balance billing families for the first partial month of coverage will be discontinued; instead the initial full month's premium will cover the first entire calendar month of coverage plus any initial partial month of coverage.
- Premium "sponsorship" rules will be modified to encourage third party sponsorship of premiums for families facing financial hard times.

Required parental copayment amounts are described in attachment C, describing the benefit package. Furthermore, family copayments for health benefits are capped at $250 for all subscribers in one household per year.

Attachment F: Measuring Progress/Rate of Uninsurance

In Section V(2) above, we have provided a brief description of the demonstration project's hypothesis and research design. Additionally, the state will review analyses of the Current Population Survey data for California as published annually by the UCLA Center for Health Policy Research. Health insurance information analyzed includes the types of coverage detailed in Section V, Accountability and Monitoring. The annual analysis also provides health insurance information for non-elderly Californians and children by family income relative to poverty, work status, age, ethnicity, immigrant and citizenship status, family composition as well as other variables.

Attachment G: Budget Worksheets And Implementation Timetable

The attached budget worksheet provides the estimated costs under the proposed waiver based on accomplishing preparations for enrolling the waiver populations in the later part of "Federal Fiscal Year 1" and opening coverage for the waiver populations at the start of "Federal Fiscal Year 2." (The distribution of costs across the fiscal years will change if enrollment begins during the course of a fiscal year.)

The State estimates that approximately 4 months will be required between the final approval of the waiver and implementation coverage for the waiver populations. This allows time for participating health plans to prepare to offer coverage to the new enrollees.

Timing of implementation of this waiver is subject to pending budget action. Current State law requires implementation of the waiver 4 months after its approval. The State budget adopted in July 2001 provided sufficient funding to implement the waiver effective October 1, 2001. Delay in approval of the waiver and intervening events have changed the implementation schedule. Without authority to implement the waiver and now faced with a significant reduction in state revenues, the Governor has proposed to initiate enrollment under the waiver on July 1, 2003. The State Legislature is meeting in special session to consider this proposal and other aspects of the state budget. Enrollment of the waiver population will occur as soon as the state's fiscal situation will allow as determined by the Governor and the Legislature.

SCHIP Section 1115 Waiver Budget Template

	Previous Fiscal Year	Federal Fiscal Year 1	Federal Fiscal Year 2	Federal Fiscal Year 3	Federal Fiscal Year 4	Federal Fiscal Year 5	Federal Fiscal Year 6 [1)]
State's allotment							
State's enhanced FMAP rate	65.88	65.88	65.88	65.88	65.88	65.88	65.88
COST PROJECTIONS OF APPROVED SCHIP PLAN							
Benefit Costs							
Insurance payments	$3,598,989	$3,181,500	$3,498,000	$3,498,000	$3,498,000	$3,498,000	$3,498,000
Managed care	$250,281,382	$391,242,590	$495,984,891	$578,992,780	$627,776,205	$658,776,130	$689,452,044
per member/per month rate @ # of eligibles	$82.05	$83.98	$84.86	$91.54	$99.21	$104.08	$108.90
Fee for Service	$21,396,691	$56,624,000	$75,660,000	$74,513,000	$73,763,000	$73,763,000	$73,763,000
Total Benefit Costs	**$275,277,062**	**$451,048,090**	**$575,142,891**	**$657,003,780**	**$705,037,205**	**$736,037,130**	**$766,713,044**
(Offsetting beneficiary cost sharing payments)	$17,667,790	$26,806,589	$34,479,102	$37,965,307	$37,479,391	$37,458,926	$37,336,136
Net Benefit Costs	$257,609,272	$424,241,500	$540,663,789	$619,038,473	$667,557,814	$698,578,204	$729,376,908
Administration Costs							
Personnel		$7,515,666	$8,588,038	$8,588,038	$8,588,038	$8,588,038	$8,588,038
General administration	$25,616,483	$3,816,994	$3,495,822	$3,495,822	$3,495,822	$3,495,822	$3,495,822
Contractors/Brokers (e.g., enrollment contractors)		$24,990,113	$30,479,214	$32,765,404	$34,176,507	$34,161,648	$34,072,497
Claims Processing		$250,750	$214,000	$214,000	$214,000	$214,000	$214,000
Outreach/marketing costs	$2,606,882	$8,795,000	$8,974,198	$9,705,595	$10,496,601	$11,352,074	$12,277,268
Other		$0	$0	$0	$0	$0	$0
Total Administration Costs	**$28,223,365**	$45,368,522	$51,751,272	$54,768,860	$56,970,968	$57,811,582	$58,647,625
10% Administrative Cap	$28,623,252	$47,137,944	$60,073,754	$68,782,053	$74,173,090	$77,619,800	$81,041,879
Federal Share	$186,754,005	$309,942,615	$390,993,941	$444,712,840	$478,188,996	$499,217,259	$520,096,191
State Share	$95,479,643	$159,667,408	$201,421,121	$229,094,493	$246,339,786	$257,172,527	$267,928,341
TOTAL PROGRAM COSTS	$282,233,648	$469,610,022	$592,415,062	$673,807,333	$724,528,782	$756,389,786	$788,024,532

COST PROJECTIONS OF SCHIP WAIVER PROPOSAL							
Benefit Costs for Waiver Population #1 (e.g., children)							
Insurance payments		$0	$0	$0	$0	$0	$0
Managed care		$0	$0	$0	$0	$0	$0
per member/per month rate @ # of eligibles							
Fee for Service		$0	$0	$0	$0	$0	$0
Total Benefit Costs for Waiver Population #1		$0	$0	$0	$0	$0	$0
Benefit Costs for Waiver Population #2 (e.g., parents)							
Insurance payments		$0	$0	$0	$0	$0	$0
Managed care		$0	$253,701,504	$540,155,435	$721,979,519	$753,485,377	$520,551,898
per member/per month rate @ # of eligibles		N/A	$180.69	$172.02	$187.77	$195.96	$193.40
Fee for Service		$0	$3,676,471	$2,941,177	$2,941,177	$2,941,177	$1,960,786
Total Benefit Costs for Waiver Population #2		$0	$257,377,975	$543,096,612	$724,920,696	$756,426,554	$522,512,684
Benefit Costs for Waiver Population #3 (e.g., pregnant women)							
Insurance payments							
Managed care							
per member/per month rate @ # of eligibles							
Fee for Service							
Total Benefit Costs for Waiver Population #3							
Total Benefit Costs	$0	$0	$257,377,975	$543,096,612	$724,920,696	$756,426,554	$522,512,684
(Offsetting beneficiary cost sharing payments)		$0	$16,467,606	$35,213,183	$45,461,660	$44,894,614	$29,907,031
Net Benefit Costs	$0	$0	$240,910,369	$507,883,430	$679,459,036	$711,531,940	$492,605,653
Administration Costs							
Personnel		$0	$2,677,250	$1,645,000	$1,645,000	$1,645,000	$1,096,667
General administration		$5,178,205	$19,334,614	$1,000,000	$1,000,000	$1,000,000	$666,667
Contractors/Brokers (e.g., enrollment contractors)		$0	$6,469,966	$12,622,283	$15,974,181	$16,066,810	$10,703,339
Claims Processing		$0	$0	$0	$0	$0	$0
Outreach/marketing costs		$9,443,008	$38,329,023	$8,000,000	$8,000,000	$8,000,000	$5,333,336
Other (specify)		$0	$0	$0	$0	$0	$0
Total Administration Costs		$14,621,212	$66,810,852	$23,267,283	$26,619,181	$26,711,810	$17,800,010
10% Administrative Cap	$0	$0	$26,767,819	$56,431,492	$75,495,448	$79,059,104	$54,733,961
Federal Share		$9,650,000	$203,096,006	$350,559,471	$466,011,623	$487,240,875	$336,867,737
State Share		$4,971,212	$104,625,215	$180,591,242	$240,066,594	$251,002,875	$173,537,925
TOTAL PROGRAM COSTS	$0	$14,621,212	$307,721,221	$531,150,713	$706,078,217	$738,243,750	$510,405,663

Note: Federal Fiscal Year (FFY) 2001 is October 1, 2000 through September 30, 2001.

[1)] Projected Waiver Costs for FFY 06 reflect the adjusted 9-month cost from 10/05 - 6/06.

Attachment H: Waiver/Expenditure Authority Request and Justification

Waivers and Expenditure Authority Requested

Under the authority of section 1115(a)(2) of the Act, the following expenditures that would not otherwise be regarded as expenditures under title XXI will be regarded as expenditures under the state's title XXI plan:

A. Demonstration Population 1: Expenditures to provide coverage that meets the requirements of section 2103 of the Act for uninsured custodial parents, caretaker relatives and legal guardians of children eligible under the title XIX state plan or the title XXI state plan, when the parents and caretakers have family incomes at or below 200 percent of the FPL and are not eligible for Medi-Cal

B. Demonstration Population 2: Expenditures for up to a two-month coverage period for individuals whose one-year continuous eligibility ends, when the individual has been determined potentially Medi-Cal eligible but a final Medi-Cal eligibility determination has not been made, or when the individual has been determined Medi-Cal eligible but the individual has not yet been enrolled in a Medi-Cal health plan.

SCHIP Requirements Not Applicable to the Demonstration:

1. General Requirements, Eligibility and Outreach 2102

The state child health plan does not have to reflect the demonstration populations, and eligibility standards do not have to be limited by the general principles in section 2102(b). The state must perform eligibility screening to ensure that applicants for the demonstration population 1 who are eligible for Medi-Cal are enrolled in that program and not in demonstration population 1.

2. Restrictions on Coverage and Eligibility to Targeted Low Income Children 2103, 2110

Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

3. Cost Sharing 2103(e)

Rules governing cost sharing under section 2103(e)(3) shall not apply to the demonstration populations to the extent necessary to permit parents and caretaker relatives to pay cost sharing that may exceed the title XXI limits.

4. Federal Matching Payment and Family Coverage Limits 2105

Federal matching payment is available in excess of the ten percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable. Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).

5. Annual Reporting Requirements 2108

Annual reporting requirements do not apply to the demonstration populations.

Justification

This demonstration proposal and the State's previous initiatives to expand health coverage for the uninsured (described below), were predicated on the fact that a family-based approach to coverage will further increase enrollment for eligible children in those families. Several recent studies of past Medicaid expansions across the states have found that family-based expansions have significantly increased the portion of eligible children covered compared to child-only expansions. A Tulane University study found that programs offering family-based expansions would enroll 75 percent of eligible children while the children-only expansions enroll only 45 percent of eligible children. The Center for Budget and Policy Priorities found similar results in its September 2000 study. It appears that parents may be more likely to apply and enroll their child if they themselves can enroll. It is expected that a family-based approach will further increase enrollment for children. Family-based coverage not only increases the percent of eligible children covered, but also provides a necessary tool and peace of mind for working families without insurance.

According to 1999 Census Bureau data, 20 percent of Californians are uninsured — the fourth highest in the nation, compared to the national average of 16 percent. A significant percentage of California's working families, particularly those working in low-wage jobs, do not have access to insurance or, if they do, cannot afford it. Almost two-thirds of the uninsured are in families with full-time workers, and an additional 12 percent of the uninsured are in families with part-time workers.

Although employer-based coverage is the predominant form of coverage for working families, California businesses are significantly less likely to offer their employees health insurance (48%) compared to businesses throughout the United States (61%) based on 1999 data. Of particular concern are workers in small businesses, which have the lowest rates of health insurance. A higher proportion (25%) of California workers are in small businesses compared to workers in small businesses nationwide (21%). Small businesses with low-wage workers are significantly less likely to offer their workers health insurance (25% in California and 38% for small businesses nationwide).

The goal of California's proposal is to increase the number of eligible children enrolled in the State's health insurance programs by offering parent coverage. Through family-based coverage, California intends to support working families who are not offered health insurance or cannot afford it. The medial income in California is $46,500. About 40 percent of Californians are in families with incomes below 200 percent of poverty ($34,100 for a family of four) and one-third of these low-wage families are uninsured, compared to about 20 percent of all Californians.

California has already taken significant strides to covering the uninsured. The State offers a children's health insurance program, which is a combination of Medicaid (Medi-Cal for Children) and S-CHIP (Healthy Families Program). Furthermore, in order to create smoother eligibility levels between the two programs, the State expanded Medi-Cal for Children (MCC) to all children through age 18 with family incomes at or below 100 percent of FPL ($17,050 for a family of four). Previously, based on federal law which only required an age-level coverage of children born after September 30, 1983, Medi-Cal would not have fully covered children through age 18 until 2001. Recently, the state also expanded Medi-Cal coverage for the parents of these children.

California implemented the Healthy Families Program (HFP), effective July 1, 1998. Initially coverage was limited to uninsured children with family incomes above Medi-Cal levels and below 200 percent of the FPL. In November of 1999, eligibility for the HFP was expanded to 250 percent of FPL.

To align the programs, both MCC and HFP use similar eligibility rules (e.g. definition of family size and income), and provide a simplified joint mail-in application form. For example, in 1998, Medi-Cal waived the assets test for children in order to mirror HFP eligibility rules. In January 1, 2001, Medi-Cal added continuous eligibility for one year for children to further align itself with HFP. California's "Single Point of Entry" screens all joint applications for income eligibility and routes applications to either the appropriate county social service agency if the child appears eligible for Medicaid; or the HFP administrative vendor if a child appears eligible for HFP.

California aggressively markets and conducts outreach for the Children's Medi-Cal and Healthy Families programs. In the Health and Human Services Agency, the Department of Health Services, in conjunction with the Managed Risk Medical Insurance Board (MRMIB), conducts a multi-faceted community outreach and education campaign to help families learn about, and apply for, Children's Medi-Cal and Healthy Families. In addition, the State provides a $50 application assistance fee to community based organizations to assist families in filling out the joint Children's Medi-Cal/HFP application. The fee is paid when the child is successfully enrolled in either Medi-Cal or HFP. The next important step, which California can take only with the support of the federal waiver we are seeking here, is providing coverage for parents in the expectation that a family approach to enrollment will increase enrollment of eligible children.